MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Harris Methodist – Ft. Worth 1301 Pennsylvania Ave. Ft. Worth, TX 76104-2122	MDR Tracking No.: M4-03-A363-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Home Assurance Co. Box 19 c/o Flahive, Ogden & Latson 505 West 12th Street Austin, TX	Date of Injury: Employer's Name: Manheim Auctions, Inc. Insurance Carrier's No.: 023050000187060001

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/12/03	01/18/03	Inpatient Hospitalization	$30,043.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a position summary. The requestor rationale on the Table of Disputed Services states that the insurance didn't pay at stop loss rate of 75%.

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier has correctly calculated the amount owed for these dates of service. The post-audit amount was well under the $40,000 stop-loss threshold. Therefore, the per diem calculation method applied to this case. No additional reimbursement is owed to the provider.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

On April 15, 2005 a call was placed to the Requestors representative. MDR was informed that they were no longer handling this health care provider and MDR would have to call Harris Methodist-Ft. Worth. A call was placed to the health care provider and MDR was told that they didn't have medical records in the billing office and that MDR would have to call their bill collection agency. They were informed that this was a courtesy call as no additional information was received and that it was the requestor's responsibility to insure records were submitted to MDR for the dispute to be properly reviewed. Medical records have not been received.

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

As medical records were not submitted MDR is unable to determine whether this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 6 days (consisting of 6 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $6,708.00 (6 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The requestor did not submit implant invoices; therefore, MDR cannot determine the cost plus 10%.

The insurance carrier reimbursed the healthcare provider a total of $6,708.00. Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Marguerite Foster	June 9, 2005
Authorized Signature	Typed Name	Date of Decision

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____